CDC *Vital Signs* Town Hall Teleconference

Adult Smoking in the U.S.
Transcript

September 13, 2011
2:00pm – 3:00pm EST

Coordinator: Welcome and thank you all for standing by. At this time all participants are in a listen-only mode for the duration of today's conference. During the question-and-answer session please press star then 1 on your touchtone telephone. You will be prompted to record your name slowly and clearly so that you may be introduced.

Today's conference is being recorded. If you have any objections you may disconnect at this time. Now I would like to turn the call over to Dr. Greg Holzman. Sir, you may begin.

Dr. Greg Holzman: Thank you. Good afternoon everybody and welcome. My name is Dr. Greg Holzman and I'm the Deputy Director of CDC's Office of State, Tribal, Local, and Territorial Support or what we like to call OSTLTS. It's my please to welcome you to this month's *Vital Signs* Townhall Teleconference. Last week's *Vital Signs* reported on adult smoking in the United States highlights the progress that has been made in this critical public health area.

There were 3 million fewer adult American smokers in 2010 than there would have been had the prevalence not declined since 2005. People who smoke everyday, particularly heavy smokers, are smoking less. Yet the report also clearly illustrates that there is much more progress that is needed. Tobacco still remains the leading cause of premature and preventable death in the United States.

The good news is we know what works and what actions we can take to make tobacco products less accessible, affordable, attractive, and accepted and ultimately safe lives and reduce healthcare costs associated with smoking.

Many of these evidenced-based strategies are effective because of their collaborative nature, spanning policy, systems, and programmatic activities and involving a wide variety of partners at the global, federal, state, tribal, and local levels.

Released this past spring, the National Prevent Strategy emphasizes a cross sector integrated approach to living tobacco free, which is one of the seven priorities identified by the National Prevention Council in the National Prevention Strategy to help people live longer and healthier at every stage of life.

In addition to all the tobacco control measures highlighted, on the last page of September's *Vital Signs* fact sheet which focuses on adults, the National Prevention Strategy recommends implementing evidence-based strategies to reduce tobacco use by children and youth. We want adults who smoke to stop smoking but we also want our children and youth never to start smoking.

Today we will hear from our colleagues in New York and Colorado and how they have integrated many of these strategies into their State's comprehensive tobacco control program. So without further delay I would turn the teleconference over to Mamie Jennings Mabery from the Knowledge Management Branch here in OSTLTS who will introduce our speakers and facilitate the discussion portion of today's meeting. Thank you.

Mamie Jennings Mabery: Thank you so much, Doctor Holzman. So good afternoon everyone and thank you for joining us. Before we get started I want to remind everyone

that you can download today's PowerPoint presentation and see biographies for each of our presenters on our website.

The easiest way to get there is to go to http://www.cdc.gov/ostlts- that's O-S-T-L-T-S and you click twice on the town hall tab in the flash module at the top of the page. This is where you also will see the recording and the transcript of today's meeting. And they should be available by the end of the week.

If you have any problems viewing the PowerPoint presentation just right-click on the link and select save-as to download the presentation to your computer and this should eliminate any issues your browser has with opening a large file.

So now it is my pleasure to introduce our speakers for today. I'm going to introduce all of the speakers now and then each speaker will hand off to the next one.

Joining us today to provide a summary of this month's *Vital Signs* report is Dr. Terry Pechacek, Associate Director for Science in CDC's Office on smoking and health. In this role he is responsible for monitoring all scientific work within the office including the preparation of Surgeon General reports on the health consequences of tobacco use.

Our next speaker will be Dr. Jeffrey Willett. He's a Research Scientist with the New York State Department of Health and Director of the New York Tobacco Control Program. He will discuss how his State identified and implemented strong tobacco control interventions to eliminate exposure to second-hand smoke for all New Yorkers, promote tobaccos use cessation, and decrease the social acceptability of tobacco use.

And finally, I'm pleased to introduce Karen DeLeeuw, Director for the Center for Healthy Living and Chronic Disease Prevention at the Colorado Department of Public Health and Environment. Colorado was one of the four States participating in a CDC pilot project to design and implement more integrated approaches to prevent and reduce chronic disease.

Ms. DeLeeuw will provide information on how through an integrated planning process tobacco prevention and control became a priority for presenting and reducing chronic disease in Colorado.

And now I'll turn the call over to Dr. Pechacek. Terry?

Dr. Terry Pechacek: Thank you very much for that introduction and thank you for attending today's *Vital Signs* Town hall Meeting focusing on adult smoking prevalence. Next slide please.

The key messages we want to get out through this communication effort are that overall there's been a decreased observed in the prevalence of cigarette smoking among adults. However, the amount and direction of change has not been consistent year to year. We want to emphasize that sustained adequately funded comprehensive tobacco control programs could accelerate the decline in adult cigarette smoking in the United States. Next slide.

A little background, tobacco use remains the single large preventable cause of death and disease in the United States. The health consequences of tobacco use include heart disease, multiple types of cancer, pulmonary disease, adverse reproductive effects, and the acerbation of many chronic health conditions. Each year approximately 443,000 Americans die from a smoking related illness. In addition, smoking has been estimated to cost the U.S. about

$193 billion annually in direct medical expenses and lost productivity. Next slide.

In 2010, an estimated 19.3% or about 45.3 million U.S. adults were current cigarette smokers. Of these, about 78.2% or about 35.4 million smoked everyday and the remaining - excuse me, 21.8% or about 9.9 million smoked only on some days.

Prevalence was higher among men at about 21.5% than among women where they're (unintelligible) smoking with 17.3%. Adults age 25 to 44 who smoked at a rate of about 22% and those 45 to 64 smoking at a rate of 21.1% had the highest prevalence among age groups. Next slide.

Among racial ethnic groups, the non-Hispanic, American Indians, and Alaska Natives had the highest observed prevalence at 31.4% followed by non-Hispanic whites at 21% and non-Hispanic blacks at 20.6%. Smoking prevalence would - decreased with increased education and was higher among adults living below the poverty level at 48.9% than among those at or above the poverty level at - who smoked at the rate of 18.3%. Next slide.

By region, prevalence was highest in the Midwest at 21.8% and the South at 21% and was overall lowest in the Western states at 15.9%. By States, smoking problems was lowest in Utah at 9.1% and California a 12.1%. Smoking rates were highest in West Virginia at 26.8% and Kentucky at 24.8%. Next slide.

During the period of 2005 through 2010 the proportion of U.S. adults who were current smokers declined from 20.9% to 19.3% which represented approximately 3 million fewer smokers in 2010 than what had existed had

prevalence not declined since 2005. However, this decline was not uniform across the population.

Reductions were observed for people - for persons age 18-24 or 25-44 years of age, Hispanics and non-Hispanic ages. Those living at or above the poverty level and those living in the Northeast and or Midwest. No population group experienced a significant increase of smoking prevalence during 2005 to 2010.

During 2005-2010 the proportion of daily smokers who smoked one to nine cigarettes per day increased from 16.4 to 21.8 or the proportion - excuse me, who smoked 30 or more cigarettes declined from 12.7% to 8.3%. Next slide.

If overall smoking patterns continue smoking prevalence will fall to approximately 17% in the year 2020. And the National Health People's Objective to reduce smoking prevalence to 12% or less will not be met. To accelerate progress toward achieving the Health People Objective full implementation of evidence-based interventions is needed.

We know what works, sustained population strategies such as tobacco price increases, graphic health warnings on cigarette packages, and 100% smoke free policies with easily accessible cessation treatments and services are proven to decrease smoking and to reduce health burden and economic impact to tobacco rated disease in the United States.

And now I'd like to bring in Jeff Willett, Director of Control Programs for the State - New York State Health Department of Health. Jeff will discuss how to implement these high impact strategies at a State level through local levels and coalitions.

Dr.Jeffrey Willett: Thanks, Terry, and good afternoon everyone. If you go to my first slide it shows Dr. Thomas Frieden's framework for public health action, the Health Impact Pyramid, which was published in the American Journal of Public Health last year.

The Health Impact Pyramid provides a useful framework for identifying interventions that have the greatest potential to improve public health. To help illustrate how we have approached tobacco control in New York State I will provide a brief overview of the pyramid and discuss how it can be applied to tobacco control.

At the base of the pyramid are the socioeconomic factors that impact health. These underlying social determinants obviously have a tremendous impact on public health that are often beyond the ability of public health professionals to address.

The remaining tiers of the pyramid represent categories of public health interventions. Dr. Frieden points out that the potential for improving public health is greatest towards to the bottom of the pyramid because those interventions reach broader segments of society and require less individual effort to succeed.

The second tier of the pyramid include interventions that change the context to make individual's default decisions healthy. These interventions have the broadest reach and greatest potential public health impact. Interventions at this tier tend to be policy or regulatory actions designed to improve public health. An example would be fluoridated water and if you're viewing a slide at a slideshow, if you click through the slide it will provide examples of each of the tiers of the pyramid.

The third tier includes interventions that require limited contact but confirm long-term protection. So immunizations are a perfect example of interventions at this tier of the pyramid.

The fourth tier represents ongoing clinical care. For instance, the treatment of hypertension through medication and clinical oversight. At this tier, the individual effort is much greater than the lower tier than the intervention is jeopardized if either the patient or the clinician fail to adhere to treatment protocols.

And finally, the top tier represents health education and counseling where the focus is changing individual behavior. At this tier the intervention is most vulnerable to individual decision making and also the intervention that this tier also is most vulnerable to the underlying socioeconomic factors that undermine health.

If you go to the next slide I present - illustrate how the New York Tobacco Control Program uses the Health Impact Pyramid. As mentioned earlier, the interventions that have the greatest potential population impact are on the second tier.

For tobacco control these include smoke-free policies, keeping the price of tobacco products high, restricting tobacco marketing and other activities that reinforce a tobacco free norm. For instance, comprehensive smoke-free policies afford broad protection to all segments of society.

Smoke-free policies protect non-smokers from second-hand smoke, support smoker's efforts to quit, and help establish tobacco-free norms. Evaluation of New York's Clean Indoor Air Act has found significant reductions in second-hand smoke exposure, direct healthcare savings measured by reductions in

heart attack admissions, and no overall negative impact on business after our comprehensive smoke-free law went into effect.

Raising the price of tobacco products through taxes or minimum price laws is another example of a tobacco control strategy at the second tier. New York's tobacco price policies are among the strongest in the nation and have had a substantial impact on reducing smoking among both youths and adults.

The third tier represents interventions requiring limited contact but providing long term protection. Exposure to an effective tobacco control media campaign can reduce youth's susceptibility to smoke and motivate smokers to quit while those who are not exposed to the campaign do not receive the effect. Studies have found that our cessation campaigns have increased both the intention to quit and quit attempts made by smokers.

The fourth tier represents clinical intervention. Over 70% of adult smokers visit a healthcare provider each year compared to approximately 5% that will call a telephone quit line. It's critical for electronic health records to support health provider interaction with tobacco using patients.

Providers should offer strong advice to quit and assistance to patients ready to quit. Through these health system interventions we can greatly expand the reach of evidence-based smoking cessation interventions.

And finally, the top tier represents counseling and education. Prevention and cessation education, which from a population perspective are our most costly and least effective interventions, include classroom, group, and individual focused education and cessation programs.

At the base of the Tobacco Control Pyramid are the underlying social determents of tobacco use. There's a greater concentration of tobacco retailers in our poorest communities and tobacco industry documents reveal how it targets specific populations and uses advertising to glamorize tobacco use, promising attractiveness, popularity, and wealth for those who use their products.

Not surprisingly, rates of tobacco use are much higher among individuals in the lowest socioeconomic group and among individuals with poor mental health.

Given these strong underlying social forces that are prompting tobacco use we must prioritize the interventions that will have the broadest reach and impact. In tobacco control, those most effective interventions include smoke-free policies, price policies, and actions that restrict tobacco product marketing. Next slide.

Tobacco control interventions that change the context, demoralize tobacco use have the greatest impact.

Best practices for tobacco control in our experience in New York indicates that these interventions are most successful when state-wide efforts are complemented and supported by local activities. New York - the New York Tobacco Control Program funds local partners to work in communities and in specific sectors like the healthcare system to advance strong, sustainable tobacco control policies.

The next slide presents the community change model used by our local partners to foster community environments that are supportive of policies that establish and reinforce tobacco-free norms. Coalitions and other partners

create a community environment supportive of policy change by implementing a set of strategies designed to build public, political, and organizational support for tobacco control.

Over time, our partners have supported statewide efforts to implement our smoke-free policies, ensure youths are protected by keeping the price of tobacco products high, and our other program priorities.

In this model community, education refers to activities that educate the public or subsets of the public about tobacco control issues with the intention of influencing individual opinions, beliefs, and behaviors. Community education includes discrete events, earned and paid media, and other types of information dissemination. Successful community education ensures there's public support for tobacco control policies.

Community mobilization refers to engaging influential community members and organizations to publicly support and call for actions that advance tobacco control. Successful community mobilization ensures there is broad engagement from constituents including community leaders and organizations to support tobacco control policies.

Decision maker education refers to educating organizational, local, state or national policy makers about the implications of tobacco use and marketing. Successful decision maker education ensures the decision makers will make well-informed decisions when considering tobacco control policies.

By effectively educating and mobilizing the public and educating and educating government and organizational policy makers, communities become receptive to or even demand strong tobacco control policies. Next slide.

The coordination between statewide and community tobacco control activities have been instrumental in the successes that we've seen in New York State. Earlier I mentioned our successful Clean Indoor Air Act. Our local partners have worked to expand to protection from second-hand smoke by working in communities and organizations to implement smoke-free campus and building entryway policies and smoke-free park and playground policies.

New York counters pro-tobacco marketing and price promotions through our State tobacco product taxes and minimum price law. In addition, our partners are working with local communities to reduce youth exposure to tobacco marketing in and around stores. Our statewide media campaigns are supported by local partners who enhance our campaigns through local earned media. In addition, our partners use media advocacy strategies to ensure the public is well informed about any important tobacco control issues.

New York State has comprehensive smoking cessation benefits through Medicaid including coverage for smoking cessation counseling and medication. Our local partners work directly with health providers to ensure they are aware of the State benefits and are trained to provide tobacco dependence treatment to their patients.

These are just a few examples of how our tobacco control policies at the State level are enhanced through our local partners. Next slide.

As a result of our focus on inventions that have broad reach and impact we are seeing marked reductions in both youth and adult smoking in New York State. Between 2000 and 2010 youth smoking was reduced by more than half with a smoking rate among high school students dropping from 27% to 12.6%. Next slide.

Between 2000 and 2010 the adult smoking rate dropped from 21.6% to 15.5%, a relatively decline of nearly 30%.

And my last slide, we believe that the health impact framework in our community change model are - offer useful approaches for developing and implementing strong tobacco control programs by focusing on policy interventions that have broad reaching impact. And enhancing these interventions through local activities we've made substantial progress reducing smoking in New York State.

But there's still tremendous work to be done. There's still over 2.5 million smokers in New York State and our nation cannot afford to continue allowing youth to be exposed to the many pro-tobacco forces in our society.

Tobacco control is essential for improving health across a broad range of chronic diseases. Tobacco control has been identified as a winnable battle by CDC. I believe that compared to many other public health issues tobacco use is our most winnable battle.

With tobacco use there's a clear public health threat, Tobacco products that are promoted by roughly $10 billion in tobacco industry marketing every year. Tobacco control has a strong evidence based and a proven best practices framework. The experience in tobacco control show that a comprehensive, population focused approach improves public health.

Finally, there are logical revenue streams for tobacco control that do not exist for many other public health issues. Specifically, tobacco product taxes and payments from the master settlement agreement provide billions of dollars to State governments each year. A fraction of these revenues can be used to fully fund strong tobacco control programs.

Thank you very much for allowing me to present today. And now I'll turn it over to Karen DeLeeuw from the Colorado Department of Health who will discuss how to make tobacco control the foundation for other chronic disease programs.

Karen DeLeeuw: Thank you, Jeff, and thank you everyone for being on the call today. What I want to talk about a little bit is the process that Colorado went through as part of a pilot program with CDC that allowed us to approach our work in a bit more of an integrated fashion.

Colorado has been working to better align our resources and more effectively address chronic disease program for several years and part of this was a function of the tobacco tax that Colorado passed in 2004, which raised about $190 million in revenue, all of which was dedicated to health related purposes.

$25 million was allocated to the tobacco control program, which at the time was our CDC minimum. And another $25 million allocated to chronic disease programs. So we're very fortunate in that we had that revenue coming in.

But as part of that - getting ready to distribute that revenue in the form of grants we really realized that we needed to approach things a lot more strategically. So in 2006 the Division reorganized its structure to better align various programs with each other while combining common functions such as evaluation and surveillance and all media and health communications into their own centralized unit.

Needless to say, I can't go through that process in detail but what we did discover is there were many barriers that we were encountered, which in part were just the function of having CDC categorical funds, many of which were

established at different points in time. And they all had different requirements for staffing patterns and things like that.

So when in 2008 CDC presented the opportunity to apply for the Integration Pilot we were very eager to apply and to participate with the other States in that process. What we wanted to do was really have one collective mission for all of the programs working in CDC - ensure that everybody participated in one annual planning process, which is easy as it sounds because of the different funding cycles it wasn't that easy.

But because of being in the pilot we were able to do that. And then to generate one integrated work plan. And what we discovered in going through that pilot program and that planning process was a real recognition on the importance of tobacco control, which, again, may seem obvious but because we had been focused - or functioning in our categorical programs for so long I think a lot of people quite didn't understand.

So next slide please, this is really a slide that presents an overview of our integrated planning process. And on the far left sort of what you see is where we started in 2006. And you see all the categorical programs lined up next to each other. We were administering the tobacco tax funds and that's along the bottom.

But everybody was pretty much functioning in their own silo functions. And there were pretty - you know, gaps between the programs. As a result of the integrating pilot we were able to engage in this common planning process and that is represented by sort of the triangle in the middle of the diagram, which resulted in having this single work plan.

And as an outcome of that process and on the left what you see is a diagram of the categorical programs sort of in the background of the circle there. What I tried to do is represent that there was more overlap between those programs although we did not lose the integrity of the categorical programs but, again, people recognized the importance of tobacco control and prevention in order to be able to reach those chronic disease outcomes.

And what you see along the bottom, I think, is what Jeff just presented although the order got a little mixed up. But it really is about looking at those - focusing on disparities, getting people to focus on those policy and environmental changes that Jeff mentioned, really looking at mass media as an intervention.

So really it's that same pyramid, the healthcare systems and the mass media are out of order and I apologize for that, but we were, again, following that same pyramid in terms of prioritizing intervention.

What I really want to talk about is though - we came to two - or we had two guiding principles through this process and one was that we would use data and make data to drive our decision making and, two, is what we would focus on best practices and evidence-based practices that we knew what worked. So next slide please.

One of the things we did is we brought everyone, all 60 staff members, in the Center together and engaged in this common planning process. And so one of the first things we really needed everyone to do was to understand how much of a burden tobacco use was on both the health of Coloradoans and also the economic consequences.

And so we began by presenting some very simple, basic information about tobacco control. And we were very surprised at how many people, although they had worked in chronic disease prevention for years, didn't really understand this.

And so we did some things with social math like talking about, you know, everyone - you know, who had a family member who had died of cancer, who had a family member who had died of COPD. And it's amazing how many people - you know, the consequences of tobacco use have touched.

And we also talked about that $193 billion annually and what people would like to see that money going for if it wasn't being spent on, you know, conditions that were preventable. Next slide please.

This slide represents sort of the next iteration of the data, which was really being able to connect the cigarette smoking in particular to the chronic disease.

Again, you'd think this would be a no brainer but, again, I think because we'd been functioning so long in our categorical programs there was a real lack of understanding on the part of some of the chronic disease programs about how much tobacco use was sort of driving the chronic diseases that they were trying to prevent and reduce.

And so this really started to bring home so of the things and really got - began this notion of culture change in that we're all part of a team, we're all trying to accomplish these chronic disease outcomes and we can't do it alone. And we really have to work together to make some of this happen.

This third slide, and again, it's just looking at the data from another perspective. It's a little more complex and it's a deeper presentation of some of the data but it's a chronic disease systems dynamic map.

And it was really instrumental in helping people appreciate the connectedness of so much of what so many of us are engaged in but really don't understand, again, those important connections between things and how all of these things are part of a system and a change in one part of the system will bring about a change in the other part of the system.

And it also goes - this particular model goes one step further and it shows around the outer edges the interventions related to preventing and reducing tobacco that can be applied to effectuate reductions in tobacco use and exposure to second-hand smoke that then cause the reductions in disease and premature death.

So strengths or width of the blue lines leading to the smoking box, for example, represent the strength of the evidence for that particular intervention.

So again, having everyone in the same room looking at this, it was not difficult to conclude that it made sense for all the chronic disease programs for all of the staff, for all of the chronic disease partners and coalitions to look at how they could be more supportive of some of the tobacco interventions such as supporting tobacco tax increases, media campaigns, and how they could help with other proven policy interventions and what the direct benefit to them would be.

A couple of conclusions from the planning process, obviously, the categorical programs realized they couldn't reach any categorical goals without becoming

more engaged in preventing and reducing tobacco use. There was a strong recognition for the importance of primary prevention.

People really got that tobacco control has proven strategies, especially as it relates to policy and environmental change. And it really did make sense for all of the programs, the chronic disease programs, to be much more supportive of our tobacco control initiative. Next slide please.

Some examples, when I talk about more supportive, is all the chronics disease program managers are much more fluent in tobacco control now. We expect all of the chronic disease coalitions to be engaged in any tobacco related policy initiatives. And our chronic disease program managers are instrumental in making that happen.

All chronic disease programs have really seen the value in assessing for - the programs that rely on screenings, things like that, are much more engaged in wanting to assess for tobacco use and control and (unintelligible). And our chronic disease programs are quite literally willing to provide more resources to support tobacco control initiatives.

And again, one example of that is we had a quit line contract. We were running low on money before the end of the year. Both the comps - our comp cancer program and our heart disease program had some funding left from salary savings and in piecing that together we were able to really then put that towards the quit line contract and continue that work.

So just some parting slide - thoughts on this last slide, this is a - I've just described, like, a six-year process in, you know, ten minutes. This is a very iterative process and it is pretty demanding. But States do not need to be in the Integrated Pilot to do some of these things, many of these things.

And that I would argue that given the upcoming consolidated chronic disease funding and just this rapidly changing external environment that we're trying to deal with, that every State needs to see the value in taking a more integrated approach to planning and to implementing their interventions and streamlining their processes, setting priorities, and aligning resources.

So with that I will turn it back over to Mamie.